## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED C 02/18/2011	
		155651					
NAME OF PROVIDER OR SUPPLIER  HOMEVIEW CENTER OF FRANKLIN				STREET ADDRESS, CITY, STATE, ZIP CODE 651 SOUTH STATE ST FRANKLIN, IN 46131			<b></b>
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF COPPREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)		D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000				
	Licensure Survey. Tr Investigation of Comp Complaint IN0008511 lack of evidence. Survey dates: Februa 2011 Facility Number: 0003 Provider Number: 158 AIM Number: 100291 Survey Team: Patti Allen BSW, TC Diane Dierks RN Joyce Hofmann RN (I Debbie Skinner RN (I Census Bed Type: SNF/NF: 107 SNF: 6 Total: 113 Census Payor Type: Medicare: 18 Medicaid: 69 Other: 26 Total: 113 Sample: 23	Plaint IN00085110.  10 - Unsubstantiated, due to ary 13, 14, 15, 16, 17 & 18, 353 5651 330  February 16, 2011) February 16, 2011)					
	compliance with 42 C and 410 IAC 16.2 in r and State Licensure S of Complaint IN00085						
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURI	⊢		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  HOMEVIEW CENTER OF FRANKLIN  STREET ADDRESS, CITY, STATE, ZIP CODE  651 SOUTH STATE ST  FRANKLIN, IN 46131  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH CORRECTION SHOULD BE COMP	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  HOMEVIEW CENTER OF FRANKLIN   (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 Continued From page 1  STREET ADDRESS, CITY, STATE, ZIP CODE  651 SOUTH STATE ST  FRANKLIN, IN 46131   SID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMP)  COMP  TAG (COMP)  TAG (COMP)				A. BUILDING		С		
HOMEVIEW CENTER OF FRANKLIN  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 Continued From page 1  651 SOUTH STATE ST FRANKLIN, IN 46131  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMP CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 000 Continued From page 1	155651			B. WING	2	02/	02/18/2011	
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 Continued From page 1  F 000 Continued From page 1  F 000 PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 000 Continued From page 1					651 SOUTH STATE ST	DDE		
	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			( (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE COMPLETION THE APPROPRIATE DATE		
Quality review 2/22/11 by Suzanne Williams, RN	F 000	Continued From page 1		FC	000			
		Quality review 2/22/1	1 by Suzanne Williams, RN					